Print Form

UTAH DEPARTMENT OF HEALTH

UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND PREPAREDNESS
BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION

PO BOX 144103
SALT LAKE CITY, UT 84114-4103
(801) 273-2994
(800) 662-4157 toll free
(801) 274-0658 Fax

NOTICE OF INTENT

FACILITY INFORMATION

Select all that apply

☐ MEDICARE CERTIFICATION ☐ MEDICAID CERTIFICATION ☐ STATE LICENSING

PROPOSED NAME

ADDRESS

CITY | STATE | ZIP | PHONE NUMBER

ANTICIPATED OPENING DATE

CONTACT INFORMATION

All correspondence and documentation will be mailed to the contact address.

CONTACT NAME | PHONE NUMBER

STREET ADDRESS | CITY

MAILING ADDRESS | STATE | ZIP

EMAIL ADDRESS | FAX NUMBER

ALTERNATE CONTACT | PHONE NUMBER

CONSTRUCTION INFORMATION

☐ NEW CONSTRUCTION ☐ ADDITION OR REMODEL

EXISTING LICENSED CAPACITY | NEW ADDITION CAPACITY | NET CAPACITY AT COMPLETION

ANTICIPATED CONSTRUCTION START | ANTICIPATED COMPLETION

ARCHITECT INFORMATION

FIRM NAME

MAILING ADDRESS

CONTACT PERSON | PHONE NUMBER

EMAIL ADDRESS | FAX NUMBER

SERVICES TO BE PROVIDED

Please check the service(s) you intend to provide

NURSING CARE FACILITY

- ◯ SNF/NF
- ◯ SNF
- ◯ NF
- ◯ ICF/ID

Beds

Secure Unit Beds

SMALL HEALTH CARE FACILITY

- ◯ 16 Beds or less
- ◯ Type "N" (3 beds or less)
- ◯ ICF/ID

Beds

ASSISTED LIVING

- ◯ Type I
- ◯ Type II

Beds

Secure Unit Beds

ABORTION CLINIC

- ◯ Type I
- ◯ Type II

Treatment Rooms

HOSPITAL

- ◯ General
- ◯ Critical Access Hospital
- ◯ Chemical Dependency
- ◯ LTAC
- ◯ Psychiatric
- ◯ Orthopedic
- ◯ Rehabilitation
- ◯ Satellite

Beds

HOSPITAL SPECIALTY PROGRAMS

- ☐ Swing Bed Beds
- ☐ PPS Rehab Beds
- ☐ PPS Psych Beds

HOME HEALTH AGENCY

- ◯ Skilled Agency
- ◯ Branch

PERSONAL CARE AGENCY

- ◯ Personal Care Agency
- ◯ Branch

HOSPICE

- ◯ Outpatient Agency
- ◯ Inpatient Agency
- ◯ Branch

Beds

OTHER PROVIDER TYPE

- ◯ Portable X-Ray
- ◯ Birthing Center — Beds
- ◯ CORF
- ◯ Mammography — Stations
- ◯ OPT/SP
- ◯ End Stage Renal Dialysis — Stations
- ◯ RHC
- ◯ Ambulatory Surgical Center — OR's

I have read the contents of this application. By my signature, I certify that the information contained herein is true, correct, and complete, to the best of my knowledge, and I authorize the Bureau of Health Facility Licensing and Certification to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Bureau of Health Facility Licensing and Certification of this fact immediately.

Signature

Print Name

Current Date

If we have not received the formal Licensing/Certification application and/or the associated licensing fees, this request will be considered closed after 12 months.